Client Intake Form

NAME		DATE
ADDRESS		
CITY	PROV	POSTAL CODE
DAYTIME PHONE	CELL PHONE	
EMAIL ADDRESS		DATE OF BIRTH

HOW DID YOU HEAR ABOUT US? ☐ **WEBSITE** ☐ **REFERRAL** ☐ **OTHER** ____________________

OCCUPATION

FAMILY SITUATION

☐ **LIVING ALONE/ROOMMATE** ☐ **LIVING WITH PARENTS** ☐ **LIVING WITH PARTNER**

☐ **SINGLE** ☐ **MARRIED** ☐ **SEPARATED** ☐ **DIVORCED** ☐ **OTHER**

☐ **CHILDREN** **HOW MANY** ______ **AGES** ______________

WHAT OTHER TREATMENTS ARE YOU HAVING?	WHAT TREATMENTS HAVE YOU TRIED?

DO YOU SUFFER FROM ANY OF THE FOLLOWING (PLEASE RIGHT C for CURRENT or P for PAST)

__ Acid Reflux	__Cholesterol	__ High Blood Pressure	__Pain: muscles
__Acne	__Constipation	__HIV/Aids	__PMS
__ADD/ADHD	__Crohn's Disease	__Indigestion	__Poor Circulation
__Addictions	__Depression	__Infertility	__Prostate
__Allergies	__Diabetes/hypoglycemia	__Insomnia	__Repeated infections
__Anxiety/Anxiety Disorder	__Diarrhea	__Irritable Bowel Syndrome	__Runny eyes or nose
__Arm/hand numbness	__Diverticulitis	__Kidney Infection	__Seizures
__Arthritis	__Dizziness	__Kidney Stones	__Sinus stuffy/ problems
__ASD/autism/Asperger's	__Dyslexia	__Lack of Concentration	__Skin Problems/Rash/Hives
__Asthma	__Eczema	__Learning disabilities	__Sleep
__Back problems	__Endometriosis	__Liver Problems	__Sore throat
__Bipolar/mental illness	__Fainting	__Low Blood Pressure	__Stroke
__Bladder Infection	__Fatigue/Low Energy	__Low Immunity	__Tendonitis
__Bronchitis/Respiratory	__Fibromyalgia	__Low sex drive	__Thyroid Problems
__Bursitis	__Food cravings	__Menopausal problems	__Tinnitus/ear ringing
__Cancer	__Gall Bladder Attacks	__Menstrual Problems	__Twitches/ tremors
__Candida/Yeast Problems	__Genital issues	__Migraines	__Ulcers
__Canker/Cold Sores	__Hay Fever	__Mood Swings	__Urination
__Celiac disease	__Headaches	__Multiple sclerosis	__Vision problems
__Carpal Tunnel Syndrome	__Hearing problems	__Neuropathy/feet numb	__Weight Problems
__Chronic Fatigue Syndrome	__Heart Problems	__Osteoporosis	__ OTHER
__Chronic Pain	__Heavy Metals	__Pain: back, neck, shoulders	
__Colitis	__Heartburn	__Pain: joints	

ARE YOU AWARE OF ANY ALLERGIES?

☐ **NO** ☐ **YES** ____

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS?

☐ **NO** ☐ **YES (INCL. HOW LONG)**____

PLEASE LIST ANY MEDICATIONS, HERBS, VITAMINS OR SUPPLEMENTS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY MAJOR ACCIDENTS, BROKEN BONES, CONCUSSIONS, WHIPLASH, SPORTS INJURIES, ETC.:

PLEASE LIST ANY SURGERIES (WITH APPROX. AGE WHEN DONE):

HAVE YOU HAD MAJOR DENTAL WORK DONE (BRACES, TEETH REMOVED, ROOT CANALS, CROWNS, BRIDGES, IMPLANTS, OR A LOT OF AMALGAM (SILVER FILLINGS.) :

ARE YOU HAPPY WITH YOUR WEIGHT?	ARE YOU ON A SPECIAL DIET?
☐ **YES** ☐ **NO - WHAT IS YOUR IDEAL** _______________	☐ **NO** ☐ **YES -** ______________________________

DIETARY RESTRICTIONS, IF ANY (RELIGIOUS/VEGETARIAN/VEGAN/GLUTEN-FREE/DAIRY-FREE, ETC.)

DESCRIBE A TYPICAL DAY OF EATING & DRINKING

BREAKFAST

LUNCH

DINNER

SNACKS/BETWEEN MEALS

WATER INTAKE (# OF GLASSES/DAY):	COFFEE/TEA:

WHAT DO YOU DO FOR EXERCISE AND RELAXATION:

DO YOU SMOKE? (IF YES - WHAT AND HOW MANY)	DO YOU DRINK ALCOHOL? (IF YES - WHAT AND HOW OFTEN)
☐ **NO** ☐ **YES -** ______________________________	☐ **NO** ☐ **YES -** ______________________________
DO YOU USE RECREATIONAL DRUGS? (IF YES - WHAT AND HOW OFTEN)	IF NOT NOW, HAVE YOU IN THE PAST? (IF YES- WHAT/HOW OFTEN)
☐ **NO** ☐ **YES -** ______________________________	☐ **NO** ☐ **YES -** ______________________________

YOUR GENERAL STATE OF HEALTH IS:	
☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**	
NUMBER OF ANTIBIOTIC TREATMENTS IN LAST 5 YEARS?	HISTORY OF ADVERSE REACTIONS TO IMMUNIZATIONS ☐ **NO** ☐ **YES -** ________________________
ARE YOU REGULARLY EXPOSED TO TOXINS OR OTHER HAZARDS (WORK/HOME/HOBBIES, ETC.): PLEASE DESCRIBE:	
HOW WOULD YOU DESCRIBE THE EMOTIONAL CLIMATE IN YOUR HOME?	
HOW STRESSFUL IS YOUR WORK OR OTHER ASPECT OF YOUR LIFE? HOW DO YOU MANAGE THE STRESS?	
LIST ANY EMOTIONAL TRAUMAS/EPISODES, WITH ROUGH DATES, AS FAR BACK AS YOU LIKE (E.G. BEREAVEMENTS, DIVORCE, PARENTS SPLIT UP, ABUSE, ETC)	
IS THERE ANYTHING ELSE THAT YOU FEEL WOULD BE IMPORTANT FOR US TO KNOW?	
WHAT AREAS, PROBLEMS OR GOALS WOULD YOU LIKE HELP WITH NOW? (PLEASE LIST IN ORDER OF IMPORTANCE TO YOU.)	

Natural Bioenergetics is a branch of alternative medicine that incorporates bioenergetic kinesiology so that information can be gathered and monitored from the client's energy system. By using manual muscle-testing, the Natural Bioenergetics professional can determine what may be stressing the energy system and how to make corrections to it. Natural Bioenergetics does not directly treat or cure any disease or condition. However, Natural Bioenergetics does work to restore the natural energy balance of the meridian system. In turn, this energy balance helps to improve the health condition of the body. Therefore, anyone with any condition can benefit from the application of Natural Bioenergetics.

Thank you for taking the time to fill out this lengthy intake form. We look forward to working with you to optimize your health and well-being. Please read and sign the informed consent that follows.

Bioenergetics
Informed Consent for Services

Please read and sign the following statements:

I understand that I give my consent to the professionals of Bioenergetic By Design to conduct a session of Natural Bioenergetics, and/or other natural modalities such as SCENAR, essences, nutritional consulting, micro current, bioresonance, Matrix Energetics, etc. as may be appropriate, with me.

I understand that the professionals of this health centre are certified in their disciplines and will use only natural, non-invasive methods of assessment and service. I am aware that a healing reaction (commonly called "detox reaction") may occur. It is usually mild and will pass in a few days with rest and water. I may experience tiredness, irritation, digestive disturbances, soreness, a mild fever or other symptoms. If I have any concerns with a reaction I will contact my professional immediately.

I also understand that Natural Bioenergetics do NOT directly treat any physical diseases, disorders, ailments, etc. Natural Bioenergetics work is for the body's underlying energy system.

I also understand that Natural Bioenergetics is NOT psychotherapy. It deals with emotional issues on an energy level, not a conscious level. It does NOT deal with, nor is it related to parapsychology.

I understand that Natural Bioenergetics is a complementary health program and does NOT diagnose disease or conditions, nor does it replace the care of your physician. It is your responsibility to consult your physician about any medical problem or concern that you become aware of.

I understand that any advice given to me as a client at Bioenergetic By Design is not mutually exclusive from any treatment or advice I may be given by another health care provider. I understand that I am at liberty to seek, or continue, medical care from any other health care provider qualified to practice in the province. I understand that the staff of Bioenergetic by Design reserve the right to determine which cases fall outside of their scope of practice and an appropriate referral will be recommended.

I understand that I am accepting or rejecting this care by my own free will. No employee or healthcare provider at Bioenergetic By Design is suggesting to me to refrain from seeking the advice of another health care provider.

I understand that the services offered are not covered by MSP and are payable at time of service. Submission to any insurance plan that may provide coverage for the service is my sole responsibility.

I understand the 48 hours notice is required for appointment cancelation; otherwise, I will be responsible for the cancelation fee of 50% of the time booked.

I understand that any modalities recommended will be explained to me in full by the staff of Bioenergetic by Design and that I will give consent to treatment based on informed consent.

☐ I consent to receive receipts, appointment notifications, follow-up and educational emails from Bioenergetic By Design and Check Appointments, our online booking calendar.

I, ________________________________, have read, understood, and agree to the above statements.

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SIGNATURE (or PARENTAL GUARDIAN'S SIGNATURE) **DATE**

Please print Parent's name if signing for a minor: ________________________________